Section (Primary Department) **Quality Management**		**SUBJECT (Document Title)** **Medical Record Documentation and Confidentiality Standards - CA**	
Effective Date 01/10/2002	**Date of Last Review** 12/18/2023	**Date of Last Revision** 12/18/2023	**Dept. Approval Date** 12/18/2023
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medi-Cal (Plan) has medical record documentation standards and confidentiality requirements that require physicians and other practitioners to maintain medical records in a manner that is current, organized and permits effective and confidential member care and quality review.

The Plan performs medical record reviews (MRRs) using the most current MRR Tools and Standards issued by the Department of Health Care Services (DHCS) to assure primary care practitioners (PCP) and OB/Gyns acting as PCPs are in compliance with the medical record documentation and confidentiality standards as outlined in DHCS Managed Care Quality & Monitoring Division (MCQMD) All Plan Letter 22-017. The Plan's MRR process, including monitoring of any required Corrective Action Plan (CAP), is outlined in policy *CA_QMXX_013 Facility Site and Medical Record Review Process-CA*.

DEFINITIONS:

None

PROCEDURE:

The MRRs are conducted to review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records or lack of documentation implies the PCP did not provide quality, timely, or appropriate medical care.

I. Medical Record Components

1. **Format:** A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.
2. **Documentation:** Well-documented records facilitate communication and coordination and promote efficiency and effectiveness of treatment.
3. **Coordination and Continuity of Care:** Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment, and future plans of care. Appointments are scheduled according to patients stated clinical needs within the timeliness standards. Missed/broken appointment shall be documented in the member's medical record. Documentation of missed appointment(s), phone or letter contact attempt(s) to reschedule an appointment, or member/parent refusal shall be documented by the PCP's office staff. Best practice is for at least three (3) attempts by telephone or letter to contact the member to determine the reason for a missed appointment but this is not required by DHCS. The PCP's office staff will attempt to reschedule the appointment and document the attempts, including the corresponding dates in the medical record. PCPs are strongly encouraged to monitor missed/broken appointments and contact the Plan with any questions and/or concerns. The presence of a system for follow-up with members who have missed an appointment is also verified during facility site reviews.
4. **Preventive Care:** The medical record shall contain evidence of appropriate preventive health services as appropriate for the age, gender and/or condition of the member.
    a. **Pediatric Preventive Services** (0-20 years old) are provided in accordance with current American Academy of Pediatrics (AAP) bright future and U.S. Preventive Task Force (USPSTF) A & B Recommendations including an Initial Health Appointment (IHA) for children, which is further described in policy *CA_PCXX_003 Initial Health Appointments for Children and Adults - CA* and age-appropriate subsequent, comprehensive physical, mental and behavioral evaluations and education.
    b. **Adult Preventive Services** (21 years and older) are provided in accordance with current U.S. Preventive Services Task Force (USPSTF) A & B Recommendations including an Initial Health Appointment (IHA) for adults, which is further described in policy *CA_PCXX_003 Initial Health Appointments for Children and Adults* – CA and age-appropriate subsequent, comprehensive physical, mental and behavioral evaluations and education.
    c. **Perinatal (Obstetrics) Preventive** assessments are provided in accordance with current American College of Obstetrics and Gynecologists (ACOG)

standards and Comprehensive Perinatal Services Program (CPSP) Guidelines.

II. Privacy and Confidentiality of Medical Records

Network practitioners and providers shall agree to maintain the confidentiality of member information and information contained in a member's medical records according to the Health Information Privacy and Accountability Act (HIPAA) standards and will only release such information as permitted by applicable federal, state and local laws and that is:

- Necessary to other providers and the health plan related to treatment, payment, or health care operations; or
- Upon member's signed and written consent.

This does not prevent physicians and providers from releasing information which he/she has taken from such medical records to organizations, public health entities or individuals taking part in research, experimental, educational, or similar programs, if no identification of a member is made in the released information.

a. Medical records in providers' offices (at each site) shall be secured and inaccessible to the public but should be readily accessible to authorized personnel. Patient information shall be accessible only to authorized staff within the provider's office, the Plan, the California DHCS, CMS, the United States Department of Health and Human Services, the United States Department of Justice, DMHC or the Inspector General of the United States or their duly authorized representatives, upon request. Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.

Electronic record keeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to ensure that recorded input is unalterable.

The office site will delegate a staff member the responsibility of securing and maintaining medical records at each site to allow for easy access by only authorized personnel. And there should be evidence that the office staff receive periodic training in member information confidentiality.

III. Medical Record Release

The patient or legal representative may consent in writing to release his/her medical information, identifying the specific medical information to be released and the release terms, such as to whom records are released and for what purposes.

All information obtained by the Plan personnel and providers' offices about a member's care or treatment shall be held confidential and shall not be divulged without the member's authorization, unless:

- It is required by law
- It is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate payment.
- It is necessary in compelling circumstances to protect the health or safety of an individual.

Enrollee records may be disclosed to qualified personnel for the purpose of conducting focus study reviews and quality of care investigations. These records may not identify, directly or indirectly, an individual enrollee in any report of the research or otherwise disclose participant's identity in any manner.

Network practitioners and providers shall provide the Plan and appropriate state and federal regulators with prompt access, upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, HEDIS and other studies within 10 days of the request unless otherwise indicated or as agreed upon.

IV. Provider Office Responsibility for Medical Records

Medical records and related information shall be retained per state and federal rules and regulations and Plan standards as outlined in the Participating Physician Agreement.

DHCS requires all providers to report immunization information in their own systems within 24 hours and to public health data systems such as the California Immunization Registry (CAIR) within fourteen (14) days of administering an immunization (within 72 hours for COVID 19 vaccines according to APL 20-017). If the provider does not offer vaccines administration, the site staff are required to utilize the registry to access the member's immunization record.

V. Provider Education

Providers are informed of medical record standards through at least one of the following:

- Provider Manual
- Provider Training by Clinical Quality staff
- Provider Newsletter/Bulletin
- Provider Website
- Facility Site Review

VI. Health Plan Responsibility for Medical Records

The Plan will securely maintain all records and documentation necessary to verify information and reports required by statute, regulation, or contractual obligation for 10 years from the end of the fiscal year in which the plan contract expires or is terminated. The Plan has designated a records coordinator who is responsible for the implementation of and compliance with record management procedures.

The Plan will monitor the PCP office site medical record documentation, confidentiality, retention, and access processes as part of the MRR process.

An analysis of medical record results is included in the annual Quality Improvement Program Evaluation.

REFERENCES:

- All Plan Letter 18-004 Immunization Requirements
- CA_PCXX_003: Initial Health Appointments for Children and Adults – CA
- CA_PCXX_009: EPSDT-Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA
- CA_PCXX_011: Adult Preventive Services
- CA_QMXX_013: Facility Site and Medical Record Review
- California Code of Regulations: Title 22, Section 53861, Title 22, Section 75055 and Title 28, Section 1300.80(b)(4)
- California Medicaid Medi-Cal, Provider Manual
- CareMore Physician Contract
- DHCS MCQMD All Plan Letter 20-022 *COVID-19 Vaccine Administration*
- DHCS MCQMD All Plan Letter 22-017 *Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review*

- DHCS MCQMD All Plan Letter 22-030 *Initial Health Appointment* (supersedes DHCS APL 13-017 and DHCS Policy Letters 13-001 and 08-003)
- Medi-Cal Managed Care Program (MCMCP) *PARTICIPATING PHYSICIAN AGREEMENT* Section VIII, 8.1-8.5
- Medical Record Review Tools and Standards 2020 - Attachment B

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management

Secondary Department(s):
CareMore (Duals)
Medicaid State Ops
Provider Relations

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
07/30/12	• Changed SSB to Medicaid • Removed most of the criteria under each section and instead will refer to the most current medical record review tool • Included references to CAPs for practitioners who score <80% • Removed most of the criteria under the Provider Responsibility section and instead will refer to the most current provider contract • Added Provider Website to list of sources for provider education
10/09/12	• Changed PL 11-013 to 12-006
04/03/13	• Added Medicare-Medicaid Plan to the plans covered by this policy • Changed policy to be more generic to be inclusive of both Medi-Cal and Medicare-Medicaid processes
08/21/13	• Section II. Changed format section to criteria section • Added more detailed verbiage regarding documentation of medical records. • Section III. Changed format section to coordination/continuity of care section • Included IHEBA/SHA in the Pediatric Preventive Criteria

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Review Date	Changes
	• Included SPD SHA in the Adult Preventive Criteria • Added medical records should be submitted within 10 days or as agreed upon • Added analysis of medical record results is included in the annual QI Program Evaluation • Added MRR results are included in the QI Program Evaluation
09/17/14	• Updated PL 02-02 to 14-004
09/24/15	• Reviewed; only minor verbiage changes required
05/19/16	• Off-cycle edit to update Primary department from Quality Management to Vendor Selection Oversight Committee (VSOC)
11/09/16	• Annual Review • Updated Primary department from Vendor Selection Oversight Committee (VSOC) to Quality Management. • Reviewed and updated MRR processes.
12/28/17	• Annual review – no changes
02/27/18	• Off-cycle edit - Added verbiage to be compliant with APL 18-004
01/14/19	• Annual review – no changes
02/17/20	• Annual review • Secondary department name change from Provider Engagement and Contracting to Provider Solutions • Check box marked to apply policy to “MMP/Duals”
05/05/20	• Off-cycle edits based on the release of DHCS All Plan Letter 20-006 (e.g. updated Medical Record Components, CAIR reporting and utilization requirements, etc.) • Replaced DHCS PL 14-004 with DHCS APL 20-006 • Removed DHCS PL 12-006 (Physical Accessibility Review Survey) • Updates made to the policy, procedure, and references
01/19/21	• Annual review • Updated Provider Education and Health Plan Responsibility sections • Updated References section by adding MCQMD to the source of APL 20-006
12/22/21	• Annual review – minor grammatical correction
11/16/22	• Annual Review • Updated Policy section • Added Definitions and Exceptions sections to match template • Minor formatting corrections to Procedure section • Updated and alphabetized References section (Updates based on the release of the DHCS MCQMD All Plan Letter 22-017; updated

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	references to the APL; removed all references to DHCS APL 20-006)
08/25/23	• Off-Cycle Review • Updates made throughout policy based on new APL requirements • Minor update made to Policy section • Updated Procedure section to add missed appointment standards under subsection, Coordination and Continuity of Care • Updated References section • Updated primary department name from "Quality Management Department" to "Quality Management" to match primary department name in header • Updated Secondary Department(s) section: o Added Medicaid State Ops o Changed Provider Solutions to Provider Relations o Removed Business Change Management and Development, Field Operations, and Privacy and Security Division
12/18/23	• Annual Review • Updated Procedure section • Updated immunization reporting period for COVID-19 vaccines per APL 20-017 requirements • Added APL 20-017 to the References section